Further interview with the IMC revealed that the client's Individual Support Plan (ISP) occurred on

revealed that the report had not been dated.

ABORATORY DIRECTOR'S OR PROVIDERUSIAPPLIER REPRESENTATIVE'S SIGNATURE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the identifulion may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued

program participation.

FORM CMS-2567(02-98) Previous Venions Obsolete

Event ID: UPIH11

Facility ID: 09G180

If continuation sheet Page 1 of 14

| A BUILDING Dentification Number Dentificat | PROVET 38-0391 EY |
|--|-------------------------|
| AND PLAN OF CORRECTION (ALTERIST AND PLAN OF CORRECTION (ALTERIST AND AND PLAN OF CORR | IO9 (XS) MPLETION |
| NAME OF PROVIDER OR SUPPLIER COMMUNITY MULTI SERVICES, INC XUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAG REGULATORY OR LSC IDENTIFYING INFORMATION) W 114 Continued From page 1 May 2, 2008, however, the date the BSP was developed could not be determined. Further review of the BSP additionally revealed that the supervising psychologist failed to sign the BSP after its development. W 124 483.420(a)(2) PROTECTION OF CLIENTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARI is not met as evidenced by: Based on interview and record verification, the facility failed to ensure the rights of each client This STANDARI is not met as evidenced by: Based on interview and record verification, the facility failed to ensure the rights of each client | (XS) MPLETION |
| COMMUNITY MULTI SERVICES, INC SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 114 Continued From page 1 May 2, 2008, however, the date the BSP was developed could not be determined. Further review of the BSP additionally revealed that the supervising psychologist failed to sign the BSP after its development. W 124 483.420(a)(2) PROTECTION OF CLIENTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (If the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARI is not met as evidenced by: Based on interview and record verification, the facility failed to ensure the rights of each client This STANDARI is not met as evidenced by: Based on interview and record verification, the facility failed to ensure the rights of each client | MPLETION |
| COMMUNITY MULTI SERVICES, INC (KA) ID PREFIX TAGE SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL TAGE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) W 114 Continued From page 1 May 2, 2008, however, the date the BSP was developed could not be determined. Further review of the BSP additionally ravealed that the supervising psychologist failed to sign the BSP after its development. W 124 483.420(a)(2) PROTECTION OF CLIENTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARI is not met as evidenced by: Based on interview and record verification, the facility failed to ensure the rights of each client. | MPLETION |
| PREFIX TAG Cach Deficiency Must be Preceded by Full REGULATORY OR LSC IDENTIFYING INFORMATION PREFIX TAG | MPLETION |
| May 2, 2008, however, the date the BSP was developed could not be determined. Further review of the BSP additionally revealed that the supervising psychologist failed to sign the BSP after its development. W 124 | |
| developed could not be determined. Further review of the BSP additionally revealed that the supervising psychologist failed to sign the BSP after its development. W 124 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARI) is not met as evidenced by: Based on interview and record verification, the facility failed to ensure the rights of each client | |
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| after its development. W 124 483.420(a)(2) PROTECTION OF CLIENTS RIGHTS The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (if the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, afteridant risks of treatment, and of the right to refuse treatment. This STANDARI is not met as evidenced by: Based on interview and record verification, the facility failed to ensure the rights of each client | |
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| The facility must ensure the rights of all clients. Therefore the facility must inform each client, parent (If the client is a minor), or legal guardian, of the client's medical condition, developmental and behavioral status, attendant risks of treatment, and of the right to refuse treatment. This STANDARI is not met as evidenced by: Based on interview and record verification, the facility failed to ensure the rights of each client | /22/0 |
| treatment, and of the right to refuse treatment. This STANDARI is not met as evidenced by: Based on interview and record verification, the facility failed to ensure the rights of each client | |
| Based on interview and record verification, the facility failed to ensure the rights of each client | |
| Based on interview and record verification, the facility failed to ensure the rights of each client | |
| and/or their legal guardian to be informed of the client's medical pondition, developmental and | |
| behavioral status, attendant risks of treatment, | |
| and the right to refuse treatment, for the one of | |
| the two clients included in the sample. (Clients #1) | |
| The finding includes: | |
| The facility failed to ensure that informed consent was obtained from Client #1 and/or his legal guardian prior to the administration of his psychotropic medications. | • |
| Observation of the medication administration on March 18, 2009 at approximately 8:45 AM, revealed Client #1 received Carbamazepine 200 mg, Fluoxetine HCL 10 mg and Zyprexa 5 mg. Interview with the medication nurse revealed that | |

| DEPAR | TIMENT OF HEALTH | AND HUMAN SERVICES & MEDICAID SERVICES | | | PRINTED: 04/17/2 FORM APPROV OMB NO. 0938-0 | VED |
|--------------------------|--|---|-------------|-----|---|------|
| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | JI-TIPLE CONSTRUCTION (X3) DATE SURVEY COMPLETED | |
| | | 09G190 | 8. WI | NG_ | G03/20/2009 | |
| NAME OF | PROVIDER OR SUPPLIER | | • | | STREET ADDRESS, CITY, STATE, ZIP CODE | |
| COMMU | INITY MULTI SERVICÈ | s, inc | | 1 | 1608 EVARTS ST, NE WASHINGTON, DC 20018 | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | PREF TAG | | PROVIDER'S PLÂN OF CORRECTION (AS) ([EACH CORRECTIVE ACTION SHOULD BE COMPLET CAPPROPRIATE DEFICIENCY) | |
| W 124 | Continued From pa | ge 2 | W | 124 | 24 | |
| | the client received this maladaptive betapitting and aggress | hese medication to address naviors(i.e. food snatching, sion). | | | | |
| • | Retardation Profess 2009, at approximate Client #1 was prescipely chotropic medical with the QMRP revealed a psychotropic treatments and habit the QMRP, Client #1 responsible person treatment, care and Further review of Climedical records on revealed a psychology, 2009, that verified documented that C render decisions reghe able to contribute | ucted with the Qualified Mental sional (QMRP) on March 19, tely 11:40 AM confirmed ribed the aforementioned ations. Further discussion ealed that the client did not give informed consent for the medications, medical ilitation services. According to 1's mother was the for signing consent for medical procedures. Lent #1's habilitation and March 20, 2009, at 11:30 AM gical assessment dated May I the QMRP's statements and lient #1 "is not competent to parding his habilitation. Nor is a to decisions regarding his efficits in both cognitive and | | | | |
| W 159 | additional interview 2009, at 2:00 PM fail Client #1's treatmen and potential side elepsychotropic medical | ED MENTAL | w | 159 | 59 | |
| | Each client's active | reatment program must be | • • | | | ٠. ا |

| | | AND HUMAN SERVICES & MEDICAID SERVICES | | • | | FORM | APPROVED 0938-0391 |
|--------------------------|--|---|--------------------|----|---|---|----------------------------|
| STATEMEN | OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) N A, BUI | | IPLE CONSTRUCTION | (X3) DATE S COMPLE | |
| | | 09G190 | B. Wil | NG | | 03/2 | 0/2009 |
| | ROVIDER OR SUPPLIER NITY MULTI SERVICE | s, inc | | 1 | REET ADDRESS, CITY, STATE, ZIP CODE 608 EVARTS ST, NE VASHINGTON, DC 20018 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL C IDENTIFYING INFORMATION) | ID PREFI TAG | | PROVIDER'S PLAN OF CORRECT (EACH CORRECTIVE ACTION SHOWN CROSS-REFERENCED TO THE APPR DEFICIENCY) | JLD BE | (X5) COMPLETION DATE |
| W 159 | This STANDARD is Based on observation review, the facility faction's active treatm coordinated and moderatal Retardation. The findings included the findings included in effective system of an effective system of the comprehensive fundamental and needs. (See W214) 3. The QMRP failed ensure Client #2's document physician's comprehensive with Client manager revealed the dosage of medication interview with the case. | ted and monitored by a production professional. In not met as evidenced by: In, interview and record liled to ensure that each lent program was integrated, nitored by the Qualified Professional (QMRP). It o ensure the implementation m of documenting a client's gram objectives. (See W252) It o ensure that a stional assessment had been lified each client's specific behavioral management. It o coordinate services to ay program was provided with | W | | 1, QMRP/ Manager will promunity activity for flonce a month to a lorestaurant and monitor implementation. Staff with receive additional traidocumentation. 2. The treating psychia will provide an annual intric assessment and/stated in the psychiatric recommendation. 3. The primary care numbered with the physician ender order | Client ocal for vill ining on atrist psych- or as ric rse will rs month | 4/25/09 5/15/09 |
| | of February 2009. program nurse confi received Depakate a further interview with physician orders we | nterview with the day rimed that Client #2's 250 mg at noon. According to the day program nurse, the re forwarded to the day wever, the group home had | | | for Client #2 and delive day program at the begin each month. | | 5/1/09 |

04/25/2009 02:54

#611 P. 006/024

| CENTER | RS FOR MEDICARE | AND HUMAN SERVICES & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) M | ULTIF | LE CONSTRUCTION | (X3) DATE SU | | |
|----------------|---|---|-------------------|-------|--|--------------|----------------------------|--|
| ND PLAN O | OF DEFICIENCIES OF CORRECTION | DENTIFICATION NUMBER: | A. BUI | | the second secon | COMPLE | ien | |
| • | | 09 G 190 | B. WIN | 10_ | | 03/20/2009 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | EET ADDRESS, CITY, STATE, ZIP CODE 508 EVARTS ST, NE | | | |
| COMMUN | NITY MULTI SERVICE | S, INC | | | ASHINGTON, DC 20018 | · | | |
| (X4) ID PREFIX | /EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE API DEFICIENCY) | | (X5) COMPLETION DATE | |
| W 159 | Continued From pa | ge 4 | W | 159 | · · · · · · · · · · · · · · · · · · · | | · | |
| | not forwarded the o | lient's March 2009 orders. | | | | | | |
| | 2009, at approxima | acility's nurse on March 19, tely 11:00 AM verified that the delivered to the day program | | , , | | | | |
| | on a monthly basis. QMRP failed to coo Client #2's day prog | At the time of the survey, the ordinate services to ensure gram received monthly | • | ļ | | | | |
| W 189 | physician orders tin 483.430(e)(1) STAI | nely. FF TRAINING PROGRAM | W | 189 | Cross reference W159 | (1) | 4/24/09 | |
| | niugitana bas leitigi | ovide each employee with g training that enables the m his or her duties effectively, netently | · | | | | a b | |
| | i emcientay, and com | F 0.0 | | | | | | |
| | Based on observative record verification, each employee with | s not met as evidenced by: ions, staff interview, and the facility failed to provide n initial and continuing training | • | | | | | |
| | that enabled the en | nployee to perform his or her and competently for one of the | | | | | • | |
| , | The finding include | | | | | | | |
| i | i effectively docume : community outing (| ensure staff was trained to nt Client #1's progress with his objective. (See W252) | | | | | | |
| ,W 214 | 483.440(c)(3)(iii) IN | IDIVIDUAL PROGRAM PLAN | . W | 214 | | | • | |
| | The comprehensive identity the client's behavioral manage | e functional assessment must specific developmental and ment needs. | | • | | | | |
| | | | | | | <i>:</i> . | | |
| | This STANDARD | is not met as evidenced by: ion, staff interview, and record | | • | 9 | | | |

| DEPAR | TMENT OF HEALTH | AND HUMAN SERVICES | | | | | | FORM | 1 APPROVED 0. 0938-0391 |
|--------------------------|--|---|---------------------|----|-------------------------|---|------------------|-------------|----------------------------|
| STATEMENT | RS FOR MEDICARE OF DEFICIENCIES OF CORRECTION | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | (X2) ML A. BUIL | | LE CONSTRU | CTION | | (X3) DATE S | SURVEY |
| | | 09G190 | B. WING | G | | | | 03/2 | 20/2009 |
| NAME OF P | ROVIDER OR SUPPLIER | | | | | , CITY, STATE, | ZIP CODE | | |
| COMMU | NITY MULTI SERVICE | s, INC | | | 18 EVARTS : ASHINGTO | ST, NE N, DC 20018 | 3 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | < | (EACH | VIDER'S PLAN CORRECTIVE A REFERENCED T DEFICIE | CTION SHOT OTHER | OULD BE | (X5) COMPLETION DATE |
| W 214 | Continued From pa | ge 5 | W 2 | 14 | | | | | |
| | review, the facility to comprehensive fund identified the clients behavioral manager | | | - | | | • | | |
| • | The findings include | E | | | | | `. | • | |
| | on March 18, 2009, revealed Client #1 rmg, Fluoxetine HCL Interview with the mithe client received this maladaptive behapitting and aggress conducted with the Professional (QMRI approximately 11:44 #1 was prescribed to | Qualified Mental Retardation) on March 19, 2009, at AM, that confirmed Client he aforementioned | | | 1. Cros | s refere | ice W15 | 59 (2) | 5/15/09 |
| - 1 | psychotropic medical Review of Client #3 records revealed he Explosive Disorder Behavior. Further revidence that a compassessments had be the client's aforements aforement use of his medication March 2009 physicipsychotropic medication that the client's paychad been adjusted. | s habilitation and medical had diagnoses that included and Obsessive Compulsive eview of the records failed to aprehensive psychiatric een conducted that verified attorned diagnoses and the earls order and the February ation review minutes revealed chotropic medication regimen At the time of the survey, the to provide evidence of a | | | | | | | |
| ; | | ne medication administration | | | 2. Cros | s refere | nce Wi' | 59 (2) | 5/15/09 |

| | | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CLIA | (X2) M | WLTI | IPLE CONSTRUCTION | (X3) DATE S | . 0938-0391 URVEY |
|--------------------------|------------------------------------|--|-------------------|---------|--|-------------|----------------------------|
| | T OF DEFICIENCIES OF CORRECTION | IDENTIFICATION NUMBER | A. BUI | | • | COMPLE | TEO |
| | | 09G190 | B. WI | YG_ | | 03/2 | 0/2009 |
| NAME OF F | PROVIDER OR SUPPLIFR | | | 9 | REET ADDRESS, CITY, STATE, ZIP COD | E | |
| COMMI | NITY MULTI SERV CE | s.inc | | 1 | 608 EVARTS ST, NE | | |
| | | | | V | NASHINGTON, DC 20018 | <u> </u> | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | | PROVIDER'S PLAN OF CORF (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (XS) COMPLETION DATE |
| W 214 | Continued From pa | ge 6 | w: | 214 | | • • | ' _ |
| | - | at approximately 9:15 AM | | | | • | 1 |
| . ' | revealed Client #2.1 | eceived Clonazepam 0.5 mg, | | | | | |
| | | 750 mg, Fluvoxamine Maleate i | | | | 1 | ! |
| | 100 mg and Nueror | ntin 600 mg. Interview with the | | | | | : · |
| -1 | medication nurse re | evealed that the client received | | | | | |
| · | these medications (| o address his maladaptive | | | | | ! |
| • | | uming, aggression, property | | | • | | |
| | damage and non-co | ompliance). | | | • | | } . |
| | latanian was sand | ucted with the QMRP on | | | • | |] |
| | | approximately 11:40 AM, that | | | | | |
| • | | was prescribed the | | | • | | ! |
| | aforementioned nat | chotropic medications. | | | | | : |
| | Further interview wa | as conducted to ascertain if | | | | | - |
| | the client had a cun | rent psychiatric assessment. | | | | | ŀ |
| • | Review of Client #2 | 's habilitation and medical | | | | | |
| | | e client had diagnoses that | | | | | l ' |
| | included intermitten | t Explosive Disorder and | | | • | | |
| | Behavior Issues. F | urther review of the records | | | | | 1 |
| | failed to evidence a | comprehensive psychiatric | | | | • | , |
| | assessments which | ventied the client's | | | | | |
| , , | psychiatric diagnos | is. At the time of the survey, | | | | <i>:</i> | |
| • | the QMRP was una | ble to provide evidence of a | | | • | , | |
| | | assessment was available. | | | 0 | | / /05 /00 |
| W 252 | 483,440(e)(1) PRO | GRAM DOCUMENTATION | · W | 252 | Cross reference Wl | 59 (1) | 4/25/09 |
| | Data relative to acc | omplishment of the criteria | | | | | |
| | | dividual program plan | | - | | | 1 |
| | | documented in measurable | - | • | | | |
| 1 | terms. | , | | | 1 | | |
| | | | | | | | |
| | • | | | | | | ` . |
| | | 1 | | | | | |
| | This STANDARD is | s not met as evidenced by: | | | | | J. |
| | Based on staff inter | view and record review the | - | | | | • |
| | facility failed to onsi | ure the implementation of an | - | | | - | · |
| , | effective system of | documenting a client's | | | j · · · | | 1 |
| | | gram objectives for one of the | - | | | | |
| | two client's in the sa | ample. (Clients #1) | | | 1 | • | |

FORM CMS-2587(02-99) Previous Versions Obsolete

To: 2024429430

04/25/2009 02:55

#611 P. 009/024

| DEPART | MENT OF HEALTH | AND HUMAN SERVICES | | | | · · · | FORM / OMB NO. | 04/17/2009 APPROVED 0938-0391 | | |
|--------------------------|--|--|--------------------|-----|--------------------------------------|-------------------------|-------------------------------|-------------------------------------|--|--|
| STATEMENT | OF DEFICIENCIES F CORRECTION | & MEDICAID SERVICES (X1) PROVIDER/SUPPLIER/CUA IDENTIFICATION NUMBER | (X2) M | | PLE CONSTRUCTION | | (X3) DATE SURVEY COMPLETED | | | |
| | | 89G190 | B. WIN | | | | 03/20 | /2009 | | |
| NAME OF P | ROVIDER OR SUPPLIER | | | | EET ADDRESS, CIT 108 EVARTS ST, N | Y, STATE, ZIP CODE E | , | | | |
| COMMUN | IITY MULTI SERVICE | S, INC | | W | ASHINGTON, D | | TION | (X5) | | |
| (X4) ID PREFIX TAG | MOACH DESIGNED | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC (DENTIFYING INFORMATION) | ID PREFI TAG | | (EACH COR | RECTIVE ACTION SHO | OTHE APPROPRIATE | | | |
| W 252 | Continued From pa | ge 7 | W 2 | 252 | ı | • | | | | |
| | The finding include | | ĺ | | | | | | | |
| · · · | The facility failed to documented on Cliemonthly. | ensure that direct care staff ent #1's program objective | | | | | 1 | | | |
| - | interview with the Condividual Program objective for Client community outing a objective stated, " [a restaurant with outlined of the condition of the conditi | , at approximately 2:00 PM, DMRP and review of Client #1's Plan (IPP) revealed a program #1 to participate in a at a local restaurant. The The client will be able to eat in the grabbing food once a month ance." Review of the program | ļ. 1 | | | | | | | |
| | collected for the manuary 2009 and the QMRP, this object monthly and the free monthly as well. A was no documented was being implemed 483.440(f)(3)(i) PR | nce that data had been onths of December 2008, February 2009. According to ective should be implemented equency for data collection was to the time of the survey, there is devidence that this objective ented. OGRAM MONITORING & | ! ' | 262 | | | | 1 | | |
| | CHANGE The committee sho monitor individual ging monitor behavior | ould review, approve, and programs designed to manage wior and other programs that, e committee, involve risks to | | | | | | | | |
| | Based on observa verification, the fact restrictive measure Human Rights Con | is not met as evidenced by: tion, staff interview and record cility failed to ensure that es had been approved by the mmittee (HRC) for two of the ample. (Client #1 and #2) | | | | | | • | | |
| COLL CUS 2 | 587/02-99) Previous Version | s Obsolete Event ID: UPIH | 11 | F | acility ID: 09G190 | lf a | ontinuation she | et Page 6 of 1 | | |

| DEPAR | TMENT OF HEALTH | AND HUMAN SERVICES | | · · · · · · | FORM |): U4/17/2009 // APPROVED): 0938-0391 |
|--------------------------|--|---|-------------------|--|--|--|
| STATEMEN' | RS FOR MEDICARE T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPFLIER/CLIA IDENTIFICATION NUMBER | -1` ` | MULTIPLE CONSTRUCTION | (X3) DATE COMPI | SURVEY |
| | . ' | 09G190 | B. WII | NG | 03/ | 20/2009 |
| | PROVIDER OR SUPPLIER | | | STREET ADDRESS, CITY, STA 1608 EVARTS ST, NE | ATE, ZIP CODE | |
| COMMU | NITY MULTI SERVICE | s, inc | | WASHINGTON, DC 20 | <u>;,</u> | · |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREF TAG | TX (EACH CORRECT CROSS-REFERENC | LAN OF CORRECTION IVE ACTION SHOULD BE ED TO THE APPROPRIATE FICIENCY) | COMPLETION DATE |
| W 262 | Continued From pa | ge 8 | W | 262 | | |
| | The findings include | э: | | | | |
| | failed to have docur use of psychotropic | n Rights Committee (HRC) mented evidence of approved medications and behavior lient #1 and #2 as evidence | • | | | |
| € • : • : | on March 18, 2009, revealed, Client #1 mg, Fluoxetine HCl Interview with the n the client received | he medication administration at approximately 9:45 AM received Carbamazepine 200 10 mg and Zyprexa 5 mg. nedication nurse revealed that these medications to address naviors (i.e. food snatching, sion). | | psychotropic r BSP's for Clic well as all of | approve use of medications and ent #1, and #2, a ther individuals. It dicumentation refusal. | |
| | Retardation Professions 2009, at approximation CMRP confirmed prescribed the aformedications. Further | ucted with the Qualified Mental sional (QMRP) on March 19, tely 11:40 AM, revealed that ed that the client was ementioned psychotropic or interview was conducted to C had reviewed and approved sures prior to there | | | | |
| | Committee (HRC) on November 11, 2 rights, behavior supmedications. Revieweyer, did not expensely the supmedications of the supmedica | MRP, a Human Rights committee meeting was held 008, to discuss all clients' opert plans and psychotropic w of the HRC minutes, ridence that the committee 1's psychotropic medication BSP specifically. | | | | |
| | | acility's QMRP/Incident | ٠ | | | |

To: 2024429430 04/25/2009 02:55 From: #611 P. 011/024 PRINTED: 04/17/2009 FORM APPROVED DEPARTMENT OF HEALTH AND HUMAN SERVICES OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X1) PROVIDER/SUPPLIER/CLIA DC21 MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES COMPLETED IDENTIFICATION NUMBER: AND PLAN OF CORRECTION A. BUILDING B. WNG 03/20/2009 **N9G190** STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1608 EVARTS ST. NE COMMUNITY MULTI SERVICES, INC WASHINGTON, DC 20018 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (X4) ID PREFIX EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) PREFIX CROSS-REFERENCED TO THE APPROPRIATE TAG TAG DEFICIENCY W 262 W 262 Continued From page 9 documents had been signed by the committee and approved. At the time of the survey, there was no documented evidence that the HRC had reviewed and approved Client #1's behavior support plan and psychotropic medication prior to the facility's usage. 2. Observation of the medication administration ол March 18, 2009, at approximately 9:15 АМ, revealed Client #2 received Clonazepam 0.5 mg. Divalproex Sodium 750 mg, Fluvoxamine Maleate 100 mg and Nuerontin 600 mg. Interview with the medication nurse revealed that the client received these medications to address his maladaptive behaviors (i.e. tantruming, aggression, property damage and non-compliance).

Interview was conducted with the QMRP on March 19, 2009, at approximately 11:40 AM, that confirmed Client #1 was prescribed the aforementioned psychotropic medications. Further interview was conducted to ascertain if the restrictive measures had been reviewed and approved prior to their implementation. According to the QMRP, a Human Rights Committee (HRC) committee meeting was held on November 11. 2008 to discuss all clients' rights, behavior support plan and psychotropic medication regimens. Review of the HRC minutes, however, did not provide evidence that the committee discussed Clien: #2's psychotropic medication regimen and/or his BSP. At the time of the survey, there was no documented evidence that the HRC had reviewed and approved Client #2's behavior support plan and psychotropic medication prior to the facility's usage. W 331 483.460(c) NURSING SERVICES

The facility must provide clients with nursing

W 331

| | | AND HUMAN SERVICES | | • | FORM | 04/17/2009 APPROVED 0938-0391 |
|--------------------------|--|---|---------------------|---|------------------------|-------------------------------------|
| STATEMEN | RS FOR MEDICARE TOF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MUI | LTIPLE CONSTRUCTION DING | (X3) DATE ST COMPLE | URVEY |
| | | 09G190 | B. WNG | | 03/2 | 0/2009 |
| | PROVIDER OR SUPPLIER NITY MULTI SERVICE | s, INC | s | TREET ADDRESS, CITY, STATE, ZIP COI 1608 EVARTS ST, NE WASHINGTON, DC 20018 | Œ | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION) | ID PREFIX TAG | PROVIDER'S PLAN OF COR (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE A DEFICIENCY) | SHOULD BE | (X6) COMPLETION DATE |
| W 331 | Continued From pa | ge 10 | . W 33 | 1 | | |
| | , services in accorda | nce with their needs. | | | | |
| M. | | | i | | | *- |
| - | | not met as evidenced by: | | | | [|
| | the facility failed to | interview and record review ensure nursing services in | | · | | |
| : | accordance with the | clients needs for one of three ne sample. (Client #2) | | | | |
| | The finding includes | 3 . | | The primary nurse vi | ll review | [|
| | | | ! | the MAR on a weekly | | · |
| | 1. The facility's nur | sing staff the facility failed to ions were administered in | | ensure proper docume | | |
| | | ysician's orders. (See W368) | | of medication admini | stration. | ! |
| | | | <u>.</u> | The QMRP and the Res | • | |
| - | | ff failed to implement an | | Manager will notify | | 1 3 |
| i | | ensure day program on time medications as | , | staff when Client #2 | ds not at | 1 |
| • | evidenced below: | on and medicalens as | i | his day program. | • | 4/30/09 |
| ! | Interview with the R | egistered Nurse on March 19, | | | | 1 |
| | 2009 at 9:27 AM, re | evealed the Client #2 day | | | | |
| | program was to forv | vard monthly Medication | i . | | • | i |
| | home. The ongoing | ords (MAR) from the group g purpose was to ensure that | ٠. | | | l i |
| | | provided current medical | | | . • | |
| | information and acc | urate prescribed medications | 1 | | | İ |
| | especially Client #2 | who received a noon dosage | | | | |
| | or Departore 250 mg | g. Further interview with the the client is prescribed this | | • | | |
| | | iagnosis of seizures. | | | | |
| | Review of the day of | rogram MAR's for November | • | | • . | |
| | 13 and 14, 2008 rev | realed that on the client was | | | | ! . |
| | absent from the day | program due to a vacation in | | | N. | |
| | | review of the MAR's during e review of nursing notes a | | | | |
| , | | ailed to provided documented | Į | | | |
| | evidence that client | was administered his noon | | 1 . | , | |

04/25/2009 02:56

#611 P. 013/024

PRINTED: 04/17/2009

| | | & MEDICAID SERVICES | | | | • | | APPROVED 0938-0391 | | |
|---------------------------------------|---|---|--|-----------------|--------------------------------------|--|------------------------|-----------------------------|--|--|
| STATEMEN | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | | ULTIPL LDING | E CONSTRUCTION | | (X3) DATE SI COMPLE | | | |
| | | 09G190 | B. WIN | G | | · · · · · · · · · · · · · · · · · · · | 03/20/200 | | | |
| | PROVIDER OR SUPPLIER NITY MULTI SERVICE | S, INC | | 160 | ET ADDRESS, CITY, 8 EVARTS ST, NE | | DE | | | |
| | | | <u>. </u> | VVA | SHINGTON, DC | S PLAN OF CORRI | ECTION | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION) | PREFU TAG | х | (EACH CORR | ECTIVE ACTION SE ENCED TO THE AP DEFICIENCY) | HOULD BE | (2/6) COMPLETION DATE | | |
| W 331 | Continued From pa | ge 11 | w 3 | 31 | | | • | | | |
| | seizure medication the day programs N revealed on the 19th | while on vacation. Review of IAR for February 2009 In the client was absent from | . : | | | | | | | |
| | QMRP he was at a | according to the staff and the schedules medical ser review of the group home | : | • | | | - | | | |
| | MAR did not eviden administered his no either of the aforem | ce that the client was on seizure medication for entioned days he was absent | | | | | , | ! ! | | |
| | form his day progra there was no docum nursing staff had an | m. At the time of the survey, nented evidence that the neffective system to ensure | | İ | | • | | | | |
| · · | medication as preso day program. | nistered his noon dosage of cribed when not attending his | İ | | | | | | | |
| W 365 | 483.460(j)(4) DRUG | REGIMEN REVIEW | W 3 | 65 | • | | | | | |
| | An individual medic must be maintained | ation administration record for each client. | | · ' | | • | | | | |
| - · · | Baséd on interview failed to establish a | s not met as evidenced by: and record reviews, the facility nd maintain a systems that ividuals medication records | | | | | į | | | |
| | were maintained for | two of the four client's ty. (Client #1 and #3) | | | | | | | | |
| | The findings include |): | | | | | | l | | |
| | for documenting Cli | ensure an effective system ent #1's presribed lence by the following: | - - | : | | | | | | |
| · · · · · · · · · · · · · · · · · · · | evidence in the MAI Divalproex Sodium | I to ensure documentated R as to why Client#1's DR 250 mg was not escribed. (See W368) | ! | | | | | | | |
| | | | _ | - 1 | | | | 1 | | |

| | | I AND HUMAN SERVICES | • | | | | | | FOR | D: 04/17/2009 M APPROVED O. 0938-0391 |
|--------------------------|---|---|--------------------|------------------|-------|-------------------|----------|--------------------|---------------------------------------|---|
| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MU A. BUIL | JLTIPLE CO | NSTRU | CTION | | | (X3) DATE | |
| • | | 09G190 | B. WIN | G | | - | · | - | 03 | /20/2009 |
| NAME OF I | ROVIDER OR SUPPLIER | <u> </u> | • | STREET AL | | CODE | · . | | | |
| COMMU | NITY MULTI SERVICE | :3, INC | | 1600 EV WASHI | | ST, NE N, DC 2 | 20018 | | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION | PREFD TAG | c | (EACH | | TIVE ACT | ION SHO HE APPR | | (X5) COMPLETION DATE |
| W 365 | Continued From pa | ge 12 | W 3 | 65 Cr | coss | refer | ence | W331 | | 4/30/09 |
| | 2. The facility failed prescribed Bactrim | to ensure that Client #1's | | | . • | | · . | ٠. | | |
| | | I to ensure Client #1's Debrox mented in the MAR. (See | | ٠ | | | • | | | |
| W 368 | | G ADMINISTRATION | W 3 | 68 | | | | | | |
| | | g administration must assure Iministered in compliance with ers. | | | | | | | | |
| | Based on interview failed to ensure that administered in acc | s not met as evidenced by: and record review, the facility t medications were ordance with physician's e two clients in the sample. | | | | | | | · · · · · · · · · · · · · · · · · · · | |
| | The findings inc ude | •: · | | ٠. | | . • | | | · · | - - |
| • | | ensure that each client medication as order by the s: | | | | | | | | |
| | interview with the mathematical three medication Adm | 009, at approximately 9:25 AM, nedication nurse and review of inistration Records (MAR) edication nurse documented | · | . į | | | | | | |
| | on March 14, 2009 Sodium DR 250 mg the client not being of the medication as | that Client #2's Divalproex was not administered due to in the group home at the time dministration. Further | | | • | | | | | |
| - - 1 | interview with nurse unaware as to if the | revealed that he/she was primary care physician had le client missed his noon | | | | | | | | |

| | | I AND HUMAN SERVICES & MEDICAID SERVICES | | | | | | | · | FORM | : 04/17/2009 APPROVED : 0938-0391 | |
|--------------------------|--|--|-------------------|--------|---|---------|---|------------|--------------------|-------------------------------|---|--|
| STATEMEN | T OF DEFICIENCIES OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | 1, -, | MULTIF | | NSTRUC | TION | | _ | (X3) DATE SURVEY COMPLETED | | |
| | | D8G190 | B. W | ING _ | | | 03/20/2009 | | | | | |
| NAME OF | PROVIDER OR SUPPLIER | | | 1 | | | CITY, STA | ATE, ZIP (| CODE | | | |
| COMMU | NITY MULTI SERVICE | 9, INC | | | | ART8 \$ | I, NE I, DC 20 | 018 | · · · · · · | <u> </u> | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SCIDENTIFYING INFORMATION | ID PREI TAI | FIX . | | (EACH C | IDER'S PL CORRECTI FERENCI DEF | VĘ ACTI | ON SHOU Œ APPRO | LD BE | (205) COMPLETION DATE | |
| W 368 | Continued From pa | ge 13 | W | 368 | C | ross | refer | rence | W331 | | 4/30/09 | |
| | day revealed the cli Review of the Phys | e medical record on the same ent had a diagnosis of seizure, ician orders revealed that the dication was prescribed for disorder. | | | | | | | | | | |
| | the RN and review Client #1 revealed I P.O. BID for 7 days | 009, at 9:33 AM, interview with of the medication records for the was prescribed Bactrim DS. Further interview revealed was prescribed for an | | į | · | | · . · | | | | | |
| | order originated on medication started the MAR did not evimedication was add in the morning or the Review of the nurse MAR failed to provide why this medication | cian's order reflected that the March 13, 2009 and the on March 14, 2009. Review of dence that the Bactrim ninistered for March 16, 2009, e evening as prescribed. es' notes and the March 2009 de documented evidence as to was not administered and/or edication was administered rescribed. | | | | | | | | | | |
| | interview with the R review of the medic that Client #1's Deb was administered o morning. The crde each ear every othe 3rd (Jan, Feb, May, Interview with the n | 109, at approximately 9:40 AM, egistered Nurse and the ation records failed to ensure rox treatment for each ear in March 2, 2009 in the further included "3 drops to further included "3 drops to July, Sept, Nov)". Further urse failed to evidence the ent was not administered as | | | | | | | | | | |
| | | | | | | | | | | | 1. | |

To: 202442943(

04/25/2009 02:56

#811 P. 016/024

| Health Regulation Administration STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA | | | OUT LANK Y | IPLE CONSTRUCTION | (X3) DATE S | (X3) DATE SURVEY | | |
|---|---|--|------------------------|---------------------------|--|------------------|-------------------------------|--|
| AND PLAN OF CORRECTION IDENTIFICATION NUM | | | A BUILDIN | | COMPLETED | | | |
| HFD03-0200 | | | <u> </u> | B. WING _ | | 03/2 | 0/2009 | |
| NAME OF P | ROVIDER OR SUPPLIER | • | | | STATE, ZIP CODE | | | |
| COMMU | NITY MULTI SERVICE | es, INC | WASHIN | arts St, Ne Gton, DC 2 | 0018 | - | | |
| (X4) ID PREFIX TAG | (FACH DEFICIENC) | ATEMENT OF DEFICIENCY MUST BE PRECEDED SCIDENTIFYING INFOR | BY FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORE (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE A DEFICIENCY) | HOULD BE | (X5) COMPLETE DATE | |
| R 000 | INITIAL COMMENT | Γ\$ | · | R 000 | | • | - | |
| | A licensure survey 18, 2009 through M was initiated using process. A random selected from a res with various disabili | larch 20, 2009. The the fundamental sun sample of two resident population of | idents was | | | | | |
| | The findings of the observations at the programs, interview administrative recoincident management | group home and to vs with staff, and the rds, including the fi | wo day te review of | t | | | | |
| - | | | | | | | | |
| : | | | | | | | | |
| | | | | | | | | |
| : | | | | | | | | |
| ealth fegul | ation Administration | DEWSUPPHER REPRES | ENTATIVE'S SI | LA CANATURE 9 | ran Otrector | 2/ | (%) DATE 240 REOT Sheet 1 o | |

#611 P. 017/024

| Health Re | egulation Administra | ation | | | | | |
|--------------------------|---|--|---------------------------|------------------------|--|-------------------------------|--------------------------|
| | OF DEFICIENCIES F CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NU | | A BUILDI | | (X3) DATE SURVEY COMPLETED | |
| | HFD03-0200 | | B. WING | | 03/2 | 0/2009 | |
| NAME OF PR | OVIDER OR SUPPLIER | | STREET AL | DRESS, CITY | STATE, ZIP CODE | 1 | |
| COMMUNI | TY MULTI SERVICE | s, inc | 1608 EVA | ARTS ST, N GTON, DC | E 20018 | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE | (X5) COMPLETE DATE |
| 1 000 1 | NITIAL COMMENT | 'S' | | 1 000 | | | |
| 1 1 ' v p : s | 8, 2009 through Ma was initiated using the process. A random | was conducted from arch 20, 2009. The he fundamental surv sample of two reside dent population of fo ies. | survey ey ents was | | | | , , |
| o p a | bservations at the coordinate of the coordinate | survey were based or group home and two s with staff, and the r ds, including the facil nt system. | day eview of | | | | |
| S E st | PACE ach window shall b tades or blinds, wh | ENTAL REQ / USE (e supplied with curta lich are kept clean, a | ins, | 1 022 | Living room, basemen window blinds will b with curtains, shade which are kept clean | e supplied | s d |
| TI B. er | ased on observatio Isure windows wer | net as evidenced by: n, the GHMRP failed e equipped with curt it were clean and in p | I to ains, | | repair. | | 5/1/09 |
| Т | ne finding includes: | | ; | | | | 5 |
| or th | i March 20, 2009, a at revealed the blin ndow and side win | ilk-through was cond at approximately 3:00 ds in the living room dow were torn. Addi ement window were i | PM, front tionally. | | | | - |
| 1 090 35 | 04.1 HOUSEKEEF | PING | | 1 090 | | | |
| ! ma an | aintained in a safe, d sanitary manner | rior of each GHMRP clean, orderly, attract and be free of | | | | | |
| ORATORY DI | Administration RECTOR'S OR PROVIDE | RISUPPLIER REARESENT | ATIVE'S SIGN | ATURE | TITLE | + 5 | XBYDATE / Q |
| ATE FORM | | | | 49 U | MANUALINA / WE | if continued | 1014101 |

04/25/2009 02:57

#611 P. 018/024

PRINTED: 04/19/2009 FORM APPROVED

| Health | Regulation Administra | ation | | | | , oran 7 (1 1 (0 V (0) |
|--|--|--|---------------------------------|---------------------|--|-------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM HFD03-0200 | | | (X2) MUL A. BUILD B. WING | ING | (X3) DATE SURVEY COMPLETED | |
| NAME OF I | PROVIDER OR SUPPLIER | | STREET AD | DRESS, CITY | STATE, ZIP CODE | 03/20/2003 |
| 1608 EVA | | | urts St, N Ston, DC | E | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY IC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROVIDENCY) | DBE COMPLETE |
| 1 090 | Continued From pag | ge 1 | i | 1 090 | | |
| į | accumulations of dir odors: | t, rubbish, and objec | tionable | , . | | |
| | Based on observation | net as evidenced by: on and interview, the o interior of the facilit and attractive manne | GHMRP | | | |
| | The findings include | : | İ | • | | |
| ! | On March 20, 2009, observation of the er following concerns: | beginning at 3:15 PM vironment revealed | /i, the | | | |
| | Internal | | .] | - | | |
| · - | An electrical outle television room had v | | | • | 1. The electrical outlet second level in the telev | ision |
| | The wood panelin a large hole. | g in the television ro | om had | | room will be repaired to exposed wires. | 3/20/09 |
| V | The radiator cove #4's bedrooms were edges. | rs in Residents #2, # obseved to have sha | 3, and arp | | The large hole in wood ing will be repaired. | pane1- 5/8/09 |
| | The upstairs bath missing the towel bar | | ıs j | : | 3. Radiator covers in Clic #3, and #1 bedrooms will paired. | be re- |
| | 5. The bathroom ceil a large crack in the b | | vel had | | 4. Towel rack will be rep | 5/8/09 Laced 5/8/09 |
| \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ | 6. The second floor to missing a soap dish. where the soap dish in the soap dish in the soap dish. | A large hole was in may have been | the tile | | 5. Bathroom ceiling on the level will be repaired. | second 5/8/09 |
| ✓ (| The radiator cover ery sharp edges. | m living room expos | sed nad | | 6. Soap dish will be repla | aced 5/8/09 |
| th Requisi | ion Administration | | <u></u> | | <u> </u> | |

UPIH11

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION IDENTIFICATION NUMBER: HFD03-0200 | | | (X2) MUI A. BUILD B. WING | · · · · · · · · · · · · · · · · · · · | (X3) DATE SURVEY COMPLETED | | |
|---|---|--|---------------------------------|---------------------------------------|--|--------------------------------|-------------------------|
| NAME OF | PROVIDER OR SUPPLIER | | STREET ADD | RESS CITY | , STATE, ZIP CODE | 03/2 | 20/2009 |
| | UNITY MULTI SERVICE | :e 1110 | 1608 EVAI WASHING | RTS ST. N | ie | | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FI SC IDENTIFYING INFORMAT | ULL ION) | ID PREFIX TAG | PROVIDER'S PLAN OF (EACH CORRECTIVE ACTI CROSS-REFERENCED TO TO DEFICIENCY | ON SHOULD BE HE APPROPRIATE | (X5) COMPLET DATE |
| 1 090 | Continued From page 8. The heating system leaking water into a | ge 2 em in the basement w bucket that had overfi | vas lowed. | 1 090 | 7. Radiator cover room will be repair | | 5/8/0 |
| | 9. The wall next to the was observed to have corresion. | he heating system at t ve water damage and | he base | | 8. The heating syst basement will be in leakage and repairs | spected for | 5/8/9 |
| | 10. The toilet seat in discolored. | the upstairs bathroon | n was | | 9. The wall next to system will be reparater damage. | | 5/8/0 |
| • | The dryer vent leading lint. Lint was observed walk and on the external line. | ng from the facility exp ed in the yard, on the erior of the house. | elled Side | | 10. The collect dear | -in westairs | 5/8/0 |
| l 203 | descriptions with each | L POLICIES Il discuss the contents in employee at the be east annually thereafte | of job | 1 203 . | Dryer vent leading facility will be in serviced. | | 5/8/0 |
| | This Statute is not m Based interview and failed to have curren employees. | net as evidenced by: record review, the GH it job descriptions for a | IMRP | | | | |
| | The finding includes: | • • | | | QMRP/ Mamager will | have all | |
| · | 3:30 PM revealed that | 20, 2009, at approximate GHMRP failed to project to the contraction of the contractions are contracted as the contraction of th | ovide for | | employees review an description annuall | | 4/24/ |
| | Retardation Profession | onal. | ricall | | | | - |
| 1 206 | 3509.6 PERSONNEL | POLICIES | ١į | 206 | • | | |
| | Each employee, prior | to employment and | Ì | , , | | • | |

| - | Regulation Administr | 1 | | | ·-···································· | | |
|--------------------------|--|---|---------------------------------------|-------------------------|--|-------------------------------|--------------------------|
| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER | | | (X2) MUL | TIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED | |
| | | | B. WING | |] | | |
| 11415 0 | F PROVIDER OR SUPPLIER | HFD03-0200 | 07055740 | DEFECT OF | | 03/2 | 20/2009 |
| INVANIE () | - PROVIDER OR SUPPLIER | | , | | , STATE, ZIP CODE | | |
| COMM | UNITY MULTI SERVICE | S, INC | | RTS ST, N STON, DC : | | a | |
| (X4) ID PREFIX TAG | (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL . | ID PREFIX TAG | PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY) | OULD BE | (X5) COMPLETE DATE |
| 1 20 | Confinued From page | ge 3 | - | 1 206 | | | |
| • | certification that a h | shall provide a physi ealth inventory has b the employee 's hea ter to perform the rec | een : Ith status i | | QMRP/ Manager will rechealth certificates fridentified direct care and consultants. | OB | 5/8/09 |
| | 1. | | ļ | | ļ | 4 | |
| | 1 | | | | | | |
| 7, W., | This Statute is not in Based on interview in | and record review, the sure that each emplo and annually thereat far physician's certific ealth inventory had the employee's health | e pyee, fter, cation ceen status | | | | |
| | The finding includes: | | | | | | |
| | Interview with the QN review of the GHMR! PM revealed that the evidence that current file for two direct care consultants. | P's personnel record GHMRP falled to pro thealth certificates w | s at 2:15 ovide | | | | |
| 1 401 | 3520.3 PROFESSIO PROVISIONS | N SERVICES: GENE | RAL | J 401 | | . | |
| ; ; | Professional services and evaluation, included developmental levels services, and service deterioration or further resident. | ling identification of and needs, treatments a designed to prever | nt it | | | | |
| illh Recul | This Statute is not m Based on interview a | et as evidenced by: nd record review, the | | | | | · . |

| Health Regulation Administra | ation | | | | FURM | APPROVED |
|--|---|--|----------------------------------|---|----------------------|--------------------------|
| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIE IDENTIFICATION NUM | R/CLIA MBER: | (X2) MUL A. BUILDI B. WING | | (X3) DATE S COMPL | |
| | HFD03-0200 | | <u> </u> | | 03/2 | 0/2009 |
| NAME OF PROVIDER OR SUPPLIER | 1 | | | , STATE, ZIP CODE | | |
| COMMUNITY MULTI SERVICE | s, inc | | RTS ST, N TON, DC | | , | |
| PREFIX ! (EACH DEFICIENCY | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F BC IDENTIFYING INFORMAT | FULL . | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTIO CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD RF. | (X5) COMPLETE DATE |
| I 401 Continued From page | ge 4 | i | l 401 | | | |
| treatment services a services to prevent | rovide diagnosis, evalund necessary follow deterioration or furthe f the five resident in to #1, #2, #3, #4) | up r loss of | | | | |
| The findings include | | | | | • | |
| on March 18, 2009 a revealed Resident# 200 mg, Fluoxetine I | tive behaviors(i.e. for | AM, zepine exa 5 revealed | | | | _ |
| Interview was condu- Mental Retardation F March 19, 2009 at a revealed Resident #1 was prescribed these psychotropic medical conducted to ascerta | Professional (QMRP) proximately 11:40 Al confirmed that the residence aforementioned that the resident had in if the resident had | on M, that esident w was a | | | | |
| current psychiatric as further added that the psychotropic medical management plan whether behaviors. | Resident #1 is presi ions and had all beha | cribed | | | | |
| Review of Resident # records revealed his of Disorder and Obsess Further review of the psychiatric assessme order to verified the reuse of his medications March 2009 phys cian psychotropic medications that the resident's psy | diagnoses: Explosive ive Compulsive Beha records failed to evidents had been conducted and diagnosis and the February review on review minutes re | ence a ted in I the w of the ruary | | | | |
| ith Regulation Administration | 4 | <u> </u> | | | 1 | <u> </u> |

04/25/2009 02:57

#611 P. 022/024

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPP IDENTIFICATION | | BER: A BUIL | | (X3) DATE S COMPL | | |
|---|---|-----------------------------------|--|----------------------|---|--|
| | HFD03-0200 | B. WIN | 6 | 03/2 | 0/2009 | |
| AME OF PROVIDER OR SUPPLIER | | STREET ADDRESS, CI | IY, STATE, ZIP CODE | | | |
| COMMUNITY MULTI SERVICE | | 1606 EVARTS ST, WASHINGTON, DO | | | | |
| PREFIX (EACH DEFICIENC) | ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FU SC IDENTIFYING INFORMATI | JLL PREFIX ON) TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | SHOULD RE | COMPLI DATE | |
| I 401 Continued From pa | ge 5 | 1401 | The treating psychia | trist will | <u>: </u> | |
| ragimon had been | editional area of | | provide a psychiatri | | , | |
| survey the OMBD | adjusted. At the time owas unable to provide | t me | | | | |
| evidence of a curre | was unable to provide nt psychiatric assessm | | ment annually and/ o | | | |
| evidence of a cu, je | nt psychiatric assessm | ent | the psychiatric reco | mendation | } - | |
| 2 Observation of # | ne medication administ | ration | | 4 | 5/15/ | |
| on March 18. 2000 | at approximately 9:15 | iauUii - | | + | ,- · - | |
| revealed Resident # | t2 receiving Clonazepa | m 0.5 | | | | |
| md: Divalores Sad | ium 750 mg, Fluvoxam | iji U,Ə i ino | | | | |
| Maleate 100 mg and | Nuerontin 600 mg. | m(e | | 1 | • | |
| Interview with the m | edication nurse reveals | ad that | | | | |
| the resident receive | d these medications to | su viai | | | | |
| address his maladar | ptive behaviors (i.e. | | | | | |
| tantruming, aggress | ion, property damage a | hni | | | | |
| non-compliance). | Freezers Samuelos C | | | | | |
| i Intensionasson condi | cted with the Qualified | i | , | i | | |
| Mental Retardation | icted with the Qualified Professional (QMRP) o | _ : | | Į. | ٠ | |
| March 19 2000 st a | pproximately 11:40 AM | Л , | | | | |
| Confirmed that Resid | lent #1 was prescribed | thosa | | . 1 | | |
| aforementioned rev | chotropic medications. | niese i | | . I | | |
| Further interview wa | s conducted to ascerta | in # | | | | |
| the resident had a cu | iment nevenietric | uru į | | | | |
| assessment. The O | MRP further added that | t the I | | | | |
| Resident #2 use nsv | chotropic medications | end | | | | |
| has a behavior mana | gement plan which ad | dress | 1 | | , | |
| his maladaptive beha | iviors. | | | | . · | |
| | | 1 | | | | |
| Review of Resident # | 2's habilitation and me | dical (| | 1 | | |
| records revealed the | resident's diagnoses: | ! | 1 . | | | |
| | Disorder and Behavio | | | 1 | | |
| Issues. Further revie | w of the records failed | to | | _ , _ l | | |
| evidence a psychiati | ic assessments which | i | | • | | |
| verified the resident p | sychiatric diagnosis. | | | i | | |
| Additionally, review o | f the March 2009 physi | ician's | | , j | • . | |
| order and the review | of the psychotropic | | | ĺ | | |
| medication minuted n | enected the current | 1 | 1 | | | |
| psychotropic medicat | ion regimen as describ | ed. | | · <u>·</u> | | |
| to applied a side a - | ey, the QMRP was un | able | | ŀ | | |
| assessment was avai | f a current psychiatric | | | | | |
| ASSESSITEM Was avai | ladie. | 1 | 1 | i | | |

04/25/2009 02:58

#611 P. 023/024

| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | | | (X2) MUL A. BUILDI B. WING | | PTRUCTION | · | СОМ | (XS) DATE SURVEY COMPLETED | |
|---|--|---|----------------------------------|--|-----------|--|----------------|-------------------------------|--------------------------|
| NAME O | F PROVIDER OR SUPPLIER | | STREET ADI | DRESS, CITY | STATE ZI | CODE | | | /20/2009 |
| | IUNITY MULTI SERVICE | s, INC | 1608 EVA | RTS ST, N TON, DC | E | | | | |
| YA4) ID PREFD TAG | X ! (EACH DEFICIENC) | TEMENT OF DEFICIENCIES MUST BE PRECEDED BY F SCIDENTIFYING INFORMAT | -ULL | ID PREFIX TAG | (E. | PROVIDER'S P ACH CORRECT SS-REFERENC DE | TVE ACTION 5 | HOULD BE | (X5) COMPLETO DATE |
| 1 47 | 74 3522.5 MEDICATIO | ONS | | 1 474 | | | - | | |
| | Each GHMRP shall medication administ resident. | maintain an individua tration record for each | al t | | Cross | referenc | e W3 31 | | 4/30/0 |
| | Based on observation review, the GHMRP ensure medication a reviewed and maintains | met as evidenced by: on, interview and reco 's nursing staff falled in idministration records ained for two of the two le. (Resident #1 and | were | | | | | | |
| | The finding includes | : | | | | | | | |
| | review of the Medica | at approximately 8:00 tion Administration Ro the nursing staff faile documentation was s: | ecords | | | | | *• • | . |
| | AM, Interview with the review of the Medica (MAR) revealed that documented on Marc | 99, at approximately 9 e medication nurse at tion Administration Rette the medication nurse the 14, 2009 that Resident 18, 2009 that Resident | nd ecords dent | | | | | | |
| | #2's Divalproex Sodii administered due to a group home at the tir administration. Furth revealed that he/she | he Resident not being ne of the medication per interview with nurs was unaware as to if | g in the | | | · · · · · · | | | |
| ; | primary care physicial Resident missed his | noon dosage of medic | cation. | | | | . • | | i |
| | Note: Review of the day revealed the Resseizure. Review of the that the aforemention prescribed for the clie | ident had a diagnosis e Physician orders re ed medication was | of vealed | and the second s | | | | | |
| | 2. On March 19, 200 | 9, at 9:33 AM, intervi | ew · | | | | • | | 1 |

04/25/2009 02:58

#611 P. 024/024

| | STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: HFD03-0200 | | | (X2) MUL A. BUILDI B. WING | | (X3) DATE 5 COMPL | |
|--------------------------|---|---|--|-------------------------------------|--|------------------------------|--------------------------|
| | PROVIDER OR SUPPLIER INITY MULTI SERVICE | s, inc | 1608 EVA | RESS, CITY, RTS ST, N TON, DC | , STATE, ZIP CODE E 20018 | | |
| (X4) ID PREFIX TAG | : (EACH DEFICIENCY | TEMENT OF DEFICIENCIE MUST BE PRECEDED BY SC IDENTIFYING INFORMA | FULL | ID PREFIX TAG | PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY) | N SHOULD BE E APPROPRIATE | (X5) COMPLETE DATE |
| 474 - | Continued From page with the RN and reverse for Resident #1 reverse Bactrim DS P.O. Bill interview revealed to prescribed for an inf | lew of the medication ealed he was prescribed for 7 days. Further tal the medication w | bed r | I 474 | | | |
| | Review of the physic order originated on I medication started of the MAR did not evid medication was admin the morning or the Review of the nurses MAR falled to provid to why this medicatic and/or evidence that administered for sev | March 13, 2009 and n March 14, 2009. If lence that the Bactri inistered for March evening as prescrib s' notes and the Man e documented evide on was not administe the medication was | the Review of m 16, 2009, bed ch 2009 ncs as | | | | |
| | 3. On March 19, 200 AM, Interview with the review of the medical that Resident #1's Downs administered on morning. The order each ear every other 3rd (Jan, Feb, May, interview with the numpurpose this treatment prescribed. | tion records falled to ebrox treatment for e March 2, 2009 in the further included " 3 of month the first throu luly, Sept, Nov)". Fu se failed to evidence | and the ensure each ear les frops to ligh the little at the | | | | |
| | | | | | | | |